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PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05053

93d

182

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Harford

County

City or town Bel Air Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William B Ayres

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary H McKee

7. Birth date of deceased (mo., day, yr.)

Aug 24 - 18746. (c) If alive, give age ✓ years

8. AGE:

Years 73

Months

Days

If less than one day

hrs. min.

9. Birthplace

ROCKS, Md

(Town, county, and state)

10. Usual occupation

Road Construction

11. Industry or business

JAMES Ayres

MOTHER FATHER

12. Name

13. Birthplace

Md

14. Maiden name

Dear Harmon

15. Birthplace

Md

16. Informant

Mrs Mary H Ayres

Address

Bel Air, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 14/48
(month) May (year) 48

Cemetery or crematory

St Ignatius

Location

Hickory Md

18. Funeral director

Joseph T Foster

Address

Bel Air, Md

19. Date record by registrar

5/13 48P. Fowrod

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County

HarfordCity or town Bel Air

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 11 1948 at 9:39 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

OCT 7 1947 to May 11 1948and that I last saw him alive on May 11 1948

Immediate cause of death

Pulmonary Edema
(Congestive Heart failure)

Due to

Due to

Other conditions Ch. HypertensionCardio-Vascular Disease 4 yr.

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

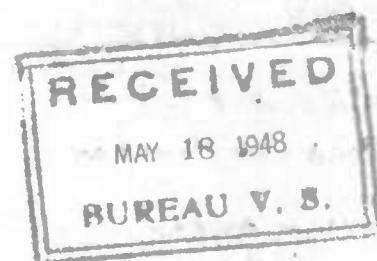
Means of injury

Injured at work?

23. SIGNATURE Wellard P Hudson M.D.

M. D. or other

Address Forest Hill Md Date signed 5/12/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05654

1246

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford
 City or town Bel Air - P. O.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Convalescent HomeHow long in hospital or institution? 5 days

3. (a) FULL NAME

John Germill Badders

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1872

6. (c) If alive, give age..... years

8. AGE: Years 75 Months 7 Days 15 If less than one day

hrs. min.

9. Birthplace New Park Pa

(Town, county, and state)

10. Usual occupation day-laborer

11. Industry or business

12. Name Samuel Badders13. Birthplace Pa14. Maiden name Agnes T. Laden15. Birthplace Pa16. Informant Mrs. Leo F. Johnson (name)Address Bel Air - P. O. 2 Md17. Burial 5/6/48 Date thereof 5/6/48
(Burial, cremation, or removal. Which?)Cemetery or crematory St. Paul Methodist CemeteryLocation near Norristown, Md.18. Funeral director Martin L. KurtzAddress Jessettsville, Md.19. 5/6/48 Date rec'd by registrar P. Lawood

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford
 City or town Rural near Norrisville
 Street No. 500 (If outside city or town limits, write RURAL and give nearest town)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 194821. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947 to May 5, 1948and that I last saw him alive on May 4, 1948Immediate cause of death Cerebrosis of LiverDURATION 6 mo.Due to Unknown

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings or operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

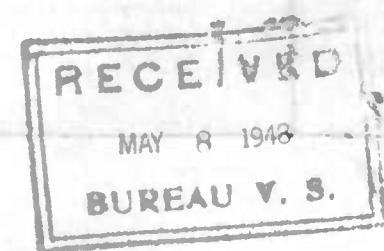
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?23. SIGNATURE Charles P. Daff M.D.

M. D. or other

Address Street, Md. Date signed 5-6-48



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. Use correct age. Is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05055

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:

County

City or town

Warford

Rural - Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Alonzo P. Baker

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary M. Flowerdew

8. (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.)

October 24th 1876

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Baltimore County, Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

John T. Baker

12. Name

Balto. Co. Md.

13. Birthplace

Hannibal Parrott

14. Maiden name

Balto. Co., Md.

15. Birthplace

Mrs. Alonzo P. Baker

16. Informant

Aberdeen, Md. P. T. D. 1

Address

Burial

Date thereof May 24 1948

(Burial, cremation, or removal. Which?)

Cemetery

Crematory

Mt. Zion

near Bel Air, Md.

Location

Henry T. Soring & Sons

Funeral director

Aberdeen, Md.

Address

May 24 1948

19. (Date reg'd by registrar)

Nellie & Riley

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Warford

City or town

Rural - Aberdeen, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Harcasons Road

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

215-03-9315

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 22 1948 at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept.

1947

to May 22

1948

and that I last saw h. in alive on

May 17

1948

Immediate cause of death

Bronchitis

DURATION

Due to arteriosclerosis

Due to myo cardiac degeneration
cardiac decompensation

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

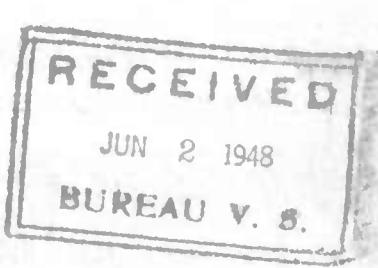
23. SIGNATURE

T. E. T. Thompson M. D. or other

Address

Aberdeen, Md.

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05056

CERTIFICATE OF DEATH

131a
Reg. Dist. No. 181

1. PLACE OF DEATH:

County Harford CoCity or town Perryman

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs

Hospital, Institution, or street address where death occurred

How long in hospital or institution?

3. (a) FULL NAME

Charles H Breunner

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MaleWhiteWidowed

6.(b) Name of husband or wife

Meta Breunner

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age

years

Nov 19th 1870

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual occupation

Stock ClerkRetired

11. Industry or business

MOTHER FATHER

12. Name Henry BreunnerGermany

13. Birthplace

Louisa SchachtGermany

14. Maiden name

Louisa SchachtGermany

15. Birthplace

Louisa SchachtGermany

16. Informant

Address

Mrs. E. HenryPerrymanMd

Burial

Date thereof May 16th

(month) (day) (year)

(Burial, cremation, or removal, which?)

Cemetery or crematory

Parkwood CemeteryRural

Location

18. Funeral director

Celrich Funeral HomeRural

Address

2008 Orleans St

19. Date rec'd by registrar

May 13 1948J. D. Lednick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MDCounty HarfordCity or town Perryman

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 17 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1947 to May 17 1948and that I last saw him alive on May 10, 1948

Immediate cause of death

Coronary Thrombosis

DURATION

1 hourDue to Chronic Cardiac Valvular Disease

Renal

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. K. Dunaway M.D.

M. D. or other

Address

Perryman Md

Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05057

CERTIFICATE OF DEATH

13102
Reg. Dist. No. 185

1. PLACE OF DEATH:

County: HanfordCity or town: Hause de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs

Hospital, institution or street address where death occurred:

Hanford Memorial Hosp.How long in hospital or institution? 3 days.

3. (a) FULL NAME

Russie Jane Carroll

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FemaleWhiteMarried

6. (b) Name of husband or wife

Raymond Carroll

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 12-1873

8. AGE:

Years

Months

Days

If less than one day

74 7 14

hrs.

min.

9. Birthplace

Cabinet Co. Md.

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

John BlackburnCabinet Co. Md.

12. Name

Margaret Bowen

13. Birthplace

Baltimore

14. Maiden name

Raymond Carroll

(Name)

15. Address

628 Linden Lane

16. Informant

Burial

(Burial, cremation, or removal, which?)

Date thereof 5/29/48

(month) (day) (year)

17. Cemetery or crematory

Angel Hill

Location

Hause de Grace

18. Funeral director

Bennington & Son

Address

Hause de Grace

19. Date rec'd by registrar

May 27, 1948

(Date rec'd by registrar)

A. L. Lewis M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: HanfordCity or town: Hause de Grace (If outside city or town limits, write RURAL and give nearest town)Street No.: 628 Linden Lane (If rural, give LOCATION)

2. (a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 26 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 23 1948 to May 26 1948and that I last saw h. et alive on May 26 1948

Immediate cause of death

ThrombosisRight lateral left.Due to Arterial sclerosisChronic nephritis

Due to

Other conditions Toxemia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

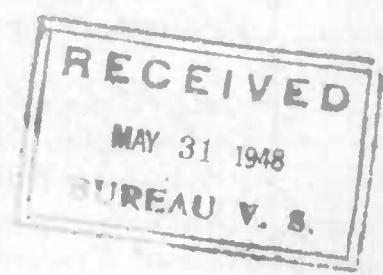
Injured at work?

23. SIGNATURE

Charles J. Felt

M. D. or other

Address Hause de Grace Date signed May 26 1948



PLEASE WRITE MAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05058

CERTIFICATE OF DEATH

Reg. Dlat. No. 185-170C

1. PLACE OF DEATH:

County

Harford

City or town Havre de Grace, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all her life

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution? 5 mos.

3. (a) FULL NAME

VERA Alice CARWELL

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Negro Married

10 years old Carwell

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

September 25, 1925

8. AGE:

Years

Months

Days

If less than one day

22

7

5

hrs. min.

9. Birthplace

Havre de Grace, Maryland

(Town, county, and state)

10. Usual occupation

Laundress

11. Industry or business

MOTHER FATHER

Howard Richardson

Havre de Grace, Md.

Ame Jean Collins

Philadelphia, Pa.

16. Informant

Mrs. Ame Jean Richardson

Address 212 Freedom St. Havre de Grace, Md.

17. Burial

Date thereof 5-4-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. James a. m. e.

Location

Havre de Grace, Md.

18. Funeral director

Elmer F. Bullock

Address

556 Lewis St. Havre de Grace, Md.

19. Date rec'd by registrar

May 4 1948

A. L. Lewis M. D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 212 Freedom St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

215-24-8196

MEDICAL CERTIFICATION

20. DATE OF DEATH

MAY 1 1948, at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on

Immediate cause of death

Myelomeningocele - level of 6th dorsal
Paraplegia

Due to Spina Card injury

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation Myelomeningocele

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Dec 1, 1947

Where did injury occur

near Havre de Grace, Maryland

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) U.S. Route #40

Means of injury Auto accident Injured at work?

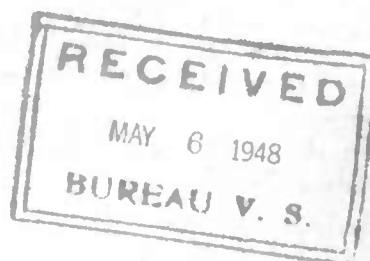
20

23. SIGNATURE

John G. Gruener, M.D.

Deputy Medical Director

Address Aberdeen, Md. Date signed 5/1/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05059

CERTIFICATE OF DEATH

93d
Reg. Dist. No. 192

1. PLACE OF DEATH:

County

Harford

City or town

Whiteford, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

86 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sidney Cooper

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white widower

6. (b) Name of husband or wife

Mary M. Cooper

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 29 - 1862

8. AGE:

Years Months Days If less than one day

86 1 11 hrs. min.

9. Birthplace

York Co. Pa.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Thomas J. Cooper

12. Name

13. Birthplace

York Co. Pa.

14. Maiden name

Sarah Bond

15. Birthplace

New York

16. Informant

Stephen Cooper

Address

Whiteford, Md.

17. Burial

Date thereof May 13 - 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Mt. Nebo Cemetery

Cemetery or crematory

Location Delta, R. D. P.

18. Funeral director

Hubert P. Stackhouse

Address Delta, Md.

19. Date rec'd by registrar

May 12 1948 M. H. Kirk

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Harford

City or town

Whiteford, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jermey 1948 May 10 1948

and that I last saw him alive on May 10 1948

Immediate cause of death

Cardiac insufficiency

DURATION

Due to

, hyperactive heart

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

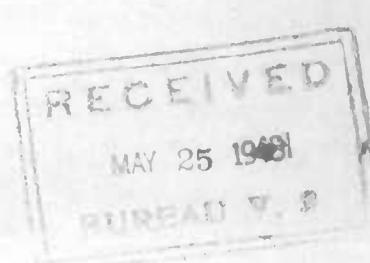
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE

M. D. or other

Address C. R. Diff Date signed 5-11-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05060

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County..... *Harford Co*City or town..... *Bellair*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

*GEORGE**GIBERSON*

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife.....

Unknown

6. (c) If alive, give age years

1898

7. Birth date of deceased (mo., day, yr.)

50

Years

Months

Days

If less than one day

..... hrs.

..... min.

9. Birthplace.....

Unknown

(Town, county, and state)

10. Usual occupation.....

Auto Body Repairman

11. Industry or business

MOTHER FATHER

12. Name..... *James G. GIBERSON**N.J.*

13. Birthplace.....

14. Maiden name.....

Unknown

15. Birthplace.....

Unknown

16. Informant.....

BENJ. MARSDEN

Address.....

*5822 W.D. T. MAN ST
Philadelphia, Pa.*

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

May 27/45

(month) (day) (year)

Cemetery or crematory.....

County Home

Location.....

Bellair Rural

18. Funeral director.....

JES J. STILLEN

Address.....

Bellair Md

19. (Date rec'd by registrar)

5/26

19

48 P. Lawrence

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Md*

County.....

*Harford*City or town..... *Bellair**Md*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 23

1948 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

19.....

and that I last saw h..... alive on.....

19.....

Immediate cause of death.....

PNEUMONIA - TYPE UNKNOWN

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

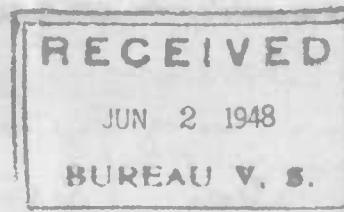
Injured at work?

23. SIGNATURE

*J. Lawrence, M.D.
deputy medical Examiner
Aberdeen, Md.*Date signed *5/23/48*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18
69
1948
1484



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05061

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:

County *Harford*City or town *Aberdeen*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *1 day*

Hospital, Institution, or street address where death occurred:

Aberdeen Auct. & Sale

How long in hospital or institution?

3. (a) FULL NAME

Joseph Goldwater

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

*Married*6. (b) Name of husband or wife *Berlie M. Goldwater*

7. Birth date of deceased (mo., day, yr.)

*Oct. 21 - 1894*6. (c) If alive, give age *53* years

8. AGE:

53

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Ireland

(Town, county, and state)

10. Usual occupation

Saleman

11. Industry or business

Maurice Goldwater

MOTHER FATHER

Maurice Goldwater

13. Birthplace

Poland

14. Maiden name

Berlie Mechanic

15. Birthplace

Ireland

16. Informant

Maurice Goldwater

Address

818 Morton Ave. Chester Pa.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *5/14/48*

(month) (day) (year)

Cemetery or crematory

Brookhaven Jewish Cem.

Location

Brookhaven Pa.

18. Funeral director

Reinman Funeral Home

Address

908 Pine St. Phila. Pa.

19. Date rec'd by registrar

May 17 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State *Maryland*County *Harford*City or town *Aberdeen*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *Paradise Road*

(If rural, give LOCATION)

2. (a) If veteran, name war...

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 12 1948 at *7 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Donald C Palmer M.D. Acting Deputy Medical Examiner

Harford County M. D. or other

Address *Baltimore Md.* Date signed *5/12/48*

RECEIVED
MAY 14 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05062

185-

Reg. Dist. No.

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Harford
City or town Hanover (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 yrs.
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Margaret S. Greenleaf4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife James H. Greenleaf (deceased)7. Birth date of deceased (mo., day, yr.) 12/18/1873 6. (c) If alive, give age years8. AGE: Years 74 Months 4 Days 15 If less than one day hrs. min.9. Birthplace Hanover (Town, county, and state)10. Usual occupation House Wife

11. Industry or business

FATHER 12. Name John Greenleaf13. Birthplace Baltimore, Md.MOTHER 14. Maiden name Margaret O'Donovan15. Birthplace Ireland16. Informant Mrs. Gladys DayAddress 823 P. Wool. Hanover17. Burial Date thereof 6/5/48 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Angel HillLocation Hanover18. Funeral director Pennington & SonAddress Hanover

19. May 5 1948 a. L. Lewis Jr. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Hanover (If outside city or town limits, write RURAL and give nearest town)Street No. 823 P. Wool. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 3 1948 at 10:40 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw her alive on

Immediate cause of death

Cerebral hemorrhageParoxysmalDiarrheametritisJaundiceOther conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of...

Where did injury occur? (City or town) (County) (State)

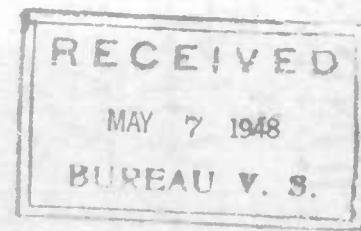
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles J. Foley, Jr.
Hannover, Maryland Date signed 7/1/48
M. D. or other



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05063

CERTIFICATE OF DEATH

183
Reg. Dist. No. 181

1. PLACE OF DEATH:

County..... Harford
City or town..... Perryman - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

HANNAHARDY

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female Colored Unknown

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... years

Unknown 1883

8. AGE:

Years

Months

Days

If less than one day
..... hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name.....

Unknown

13. Birthplace

4

14. Maiden name.....

4

15. Birthplace

4

16. Informant.....

John T. Tanning
Address 106 Rogers St Aberdeen Md

17. Burial

Date thereof May 12 1948
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Harford Cem. Home

Location

Year Sel Cir Md

18. Funeral director

Henry Tanning Sons

Address

Aberdeen Md19. May 12 48

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... HarfordCity or town..... Perryman - Rural
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 8 1948, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., fo..... 19.....

and that I last saw h..... alive on..... 19....., 19.....

Immediate cause of death.....

Drowning - AccidentalDue to Epilepsy

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

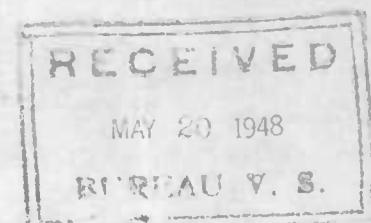
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of..... 5/12/48Where did injury occur?..... near Perryman (City or town) Harford Md (County) (State)Injured at home, farm, industry, public place (where?)..... CreekMeans of injury Fell in Creek Injured at work?..... No

23. SIGNATURE.....

John Tanning Jr. S. D.
Reputed husband John Tanning Aberdeen, Md Date signed 5/12/48

5881
59
- 8761



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05064

172

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County

Harford
Handle Grace RuralCity or town
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? not in place

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sylvester B Heagy

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Mildred Heagy

7. Birth date of deceased (mo., day, yr.)

May 21, 1915

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Manheim Lancaster Co., Pa.

(Town, County, and state)

10. Usual occupation

Mallinian
Armstrong Corp.

11. Industry or business

Howard & Heagy

MOTHER FATHER

12. Name

Lancaster Co., Pa.

Mabel Bailey

13. Birthplace

14. Maiden name

Lancaster Co., Pa.

15. Birthplace

Mildred Heagy

16. Informant

Mildred Heagy

Address

5-3-A. Charlotte St

17. Burial

Manheim, Pa.

(Burial, cremation, or removal. Which?)

Date thereof May 30, 1948
(month) (day) (year)

Cemetery or crematory

Hershey Cemetery

Location

Manheim, Pa. Cremal

18. Funeral director

Kua Patterson & Son

Address

Perryville, Md.

19. Date rec'd by registrar

May 21, 1948

(Date rec'd by registrar)

A. L. Lewis, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Pa County Lancaster

City or town

Manheim (If outside city or town limits, write RURAL and give nearest town)

Street No.

53-A Charlotte St (If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 16 1948 at 42

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from

19. 10. 19.

and that I last saw h. . . . alive on

Immediate cause of death

Drowning.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, Suicide, or homicide Date of 4-16-48

Where deceased (City or town) Lancaster (County) Md. (State)

Injured at home, farm, industry, public place, while

Meals out, while

Injured at work

Medical Examiner

Levi Dodson, M.D. Carroll County

M. D. or other

Date signed 4/21-48



CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 160c

5495
185-

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Harford
 City or town Harford Memorial Hosp.
(If outside city or town limits, write RURAL and give nearest town)
 Street address, hospital, or institution: Harrow de Grace

Length of mother's stay in County
(How many years, or months, or days. SPECIFY WHICH)

3. Name of child Holley (not named)5. Sex Male 6. Twin or triplet

FATHER OF CHILD

8. Full name Allen Stanbury Holley9. Color Col. 10. Age at time of this birth 27 yrs.11. Usual occupation Governor employee

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 2
 (b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? No During labor? No18. Pregnancy, complications of Treatment abortion19. Labor: (a) Complications of No
 (b) Induced? No20. (a) Was there an operation for delivery? No
 (b) State all operations, if any

(c) Did child die before operation?

During operation?

23. (a) Burial (b) Date thereof May, 23, 1948
(Burial, cremation or removal) (month) (day) (year)(c) Cemetery or crematory Fairview Forest Hills24. (a) Funeral director H. K. McComas & Son(b) Address Abingdon Md.

2. USUAL RESIDENCE OF MOTHER:

State Maryland
 County Harford
 City or town Edgewood
(If outside city or town limits, write RURAL and give nearest town)
 Street No. 11 Battie
(If RURAL give LOCATION)

4. Date of birth May 17 1948 Hour 9⁰⁰ P.M.7. No. of weeks pregnancy 18

MOTHER OF CHILD

12. Full maiden name Vera Marie Norman13. Color Col. 14. Age at time of this birth 23 yrs.15. Usual occupation Housewife

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes
 (b) Maternal causes Premature separation of placenta

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature: Ralph Holley M.D.
(Specify if M. D., midwife, or other)

Address Churchville Md.25. (a) May 22-48 (b) L. H. Lewis M.D.
(Date rec'd by registrar) (Registrar)26. (To be filled out if no physician was present at delivery.)
 The above certificate has been examined by me.

L. H. Lewis M.D. Health Officer, per.....

* See Instruction C on stub.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05065

Reg. Dist. No. 185

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

71 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Thomas Chew Hopkins

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

married

6. (b) Name of husband or wife

Marie Le Gass Hopkins

6. (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

3/1/1877

8. AGE:

Years

Months

Days

If less than one day

71

2

0

hrs.

min.

9. Birthplace

Hamde Grace

(Town, county, and state)

10. Usual occupation

General Insurance

11. Industry or business

Wm. W. Hopkins

12. Name

Maryland

13. Birthplace

Maryland

14. Maiden name

Cassandra Brown

15. Birthplace

England

16. Informant

Marie Le Chew Hopkins (wife)

Address

Dover Hill, Hamde Grace

17. Burial

Burial

Date thereof.....

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Darlington

Location

Darlington, Md.

18. Funeral director

Paulington & Son

Address

Hamde Grace

19. May 7 1948
(Date rec'd by registrar)A. L. Leidner
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Dover Hill

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 5 1948 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 28 to May 5 1948, and that I last saw him alive on April 28 1948

Immediate cause of death

Cerebral Embolism

DURATION

15 min

Due to

Due to

Other conditions

Hypertension

5 yrs

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. F. Magrath

M. D. or other

Address

Dalyville Md. Date signed 5/14/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05066

61

CERTIFICATE OF DEATH

Reg. Dist. No.

182

1. PLACE OF DEATH:

County

HARFORD

City or town

RURAL - FALLSTON

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 MONTHS

Hospital, Institution, or street address where death occurred:

HOME

How long in hospital or institution?

—

3. (a) FULL NAME

ALETHA ELIZA KEMERY

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife

GEORGE KEMERY

6. (c) If alive, give age. DECEASED years

7. Birth date of deceased (mo., day, yr.)

DEC 30 1875

8. AGE:

Years

Months

Days

If less than one day

72 4 13 — hrs. — min.

LUCERN CO.

9. Birthplace

PITTSTOWN, HARRISBURG, PA.

(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

12. Name JOHN COOL13. Birthplace UNKNOWN. TOWN, PENNA.14. Maiden name MARY E. TENNY15. Birthplace UNKNOWN. TOWN - PENNA.16. Informant MRS FRANK BURKE (SISTER)Address 6 UPLAND AVE. UPLAND, PA.17. Burial Upland(Burial, cremation, or removal. Which?) Baptist CemeteryDate thereof 5-15-48
(month) (day) (year)

Cemetery or crematory

Location Upland - Delaware Co. Pa.18. Funeral director William S. GylesAddress Claymont Del.19. 5/12 1948(Date rec'd by registrar) P. Fowoods

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MARYLAND

County

HARFORD

City or town

RURAL - FALLSTON.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

— FRIENDSHIP ROAD.

(If rural, give location)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

MAY 12

1948 at 9:24 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

NOVEMBER

48 to 11 MAY

1948

and that I last saw her alive on

11 MAY

1948

Immediate cause of death

CONGESTIVE HEART FAILURE

DURATION

5 DAYS

Due to ARTERIOSCLEROSIS

6 MONTHS

Due to DIABETES

7 YEARS

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

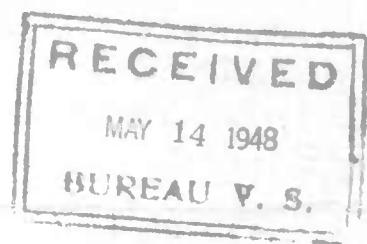
23. SIGNATURE

T. P. Sibbitt M.D.

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05067

CERTIFICATE OF DEATH

170c

Reg. Dist. No. 185-

1. PLACE OF DEATH: HarfordCounty: HarfordCity or town: Port Deposit (If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 milesHospital, institution, or street address where death occurred: Harford Memorial HospitalHow long in hospital or institution? 20 miles

3. (a) FULL NAME

Lindsey E. Lee.4. Sex: Male 5. Color or race: white 6. (a) Single, married, widowed, or divorced: Married6. (b) Name of husband or wife: Bertha E. Lee7. Birth date of deceased (mo., day, yr.): March 15, 18736. (c) If alive, give age: 65 years8. AGE: 75 Years 1 Months 16 Days If less than one day: hrs. min.9. Birthplace: Conowingo, Cecil Co., Md. (Town, county, and state)10. Usual occupation: Laborer11. Industry or business: Day12. Name: Mathology B. Lee13. Birthplace: Cecil Co., Md.14. Maiden name: Martha Brown15. Birthplace: Cecil Co., Md.16. Informant: Bertha E. LeeAddress: Port Deposit, Md.17. Burial: Burial Date thereof: May 4, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: OakwoodLocation: Conowingo, Md. Rural18. Funeral director: J. A. Patterson SonAddress: Terryville, Md.19. Date rec'd. by registrar: May 3, 1948Registrar: A. L. Lewis, M. D.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md.County: CecilCity or town: Port Deposit (If outside city or town limits, write RURAL, and give nearest town)Street No.: 94Mile: 11Town: Marl

(If rural, give LOCATION)

2. (a) If veteran, name war: _____

3. (b) Social Security Number

218-10-1014

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1, 1948

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death: Fracture ofskull.Due to: anterior force.

Due to: _____

Other conditions: _____

(Include pregnancy within 3 months of death)

Major findings of operations: _____ Date of op. _____

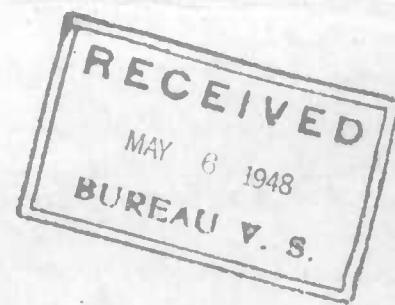
Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 5-1-48Where did injury occur: Port Deposit, Cecil Co., Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?): Routed 276Means of injury: Fell from truck Injured at work: yesMedical Examiner: W. E. Dodson, M. D. for Cecil County23. SIGNATURE: W. E. Dodson, M. D. Date signed: May 1, 1948

M. D. or other: _____ Date signed: _____



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05068

CERTIFICATE OF DEATH

94a
Reg. Dist. No. 183

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

7. Birth date of deceased (mo., day, yr.)

5. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace.....
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

MOTHER FATHER

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. May 19

(Date read by registrar)

1948 Thomas R Brown

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1948 at 10:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 13 to May 13 1948

and that I last saw him alive on May 13 1948

Immediate cause of death Coronary Thrombosis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

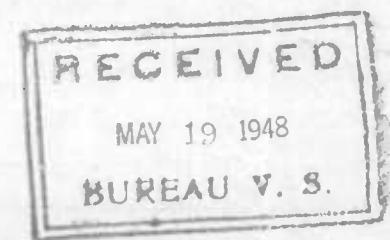
23. SIGNATURE.....

M. D. or other

Address.....

Date signed

Delta, Pa. 5/14/48



*Evidence for change
of year of birth shown on* MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05069

FILM NO. G 116 AUG 2 - 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

1. PLACE OF DEATH:

County *Baltimore* Harford

City or town *Pikeski Highway* (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *Jopps*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Clara M. Mackenzie

4. Sex *f* 5. Color or race *W.* 6. (a) Single, married, widowed, or divorced *Widowed*

6. (b) Name of husband or wife *Wallie T.*

7. Birth date of deceased (mo., day, yr.) *27/05/1876* 6. (c) If alive, give age *74* years

8. AGE: Years *74* Months Days If less than one day

hrs. min.

9. Birthplace *Baltimore - Md* (Town, county, and state)

10. Usual occupation *House wife*

11. Industry or business

12. Name *James Farmer*

13. Birthplace *Md*

14. Maiden name *Martha Ann Hayward*

15. Birthplace *Va -*

16. Informant *Mrs. Mildred R. Carter*

Address *Jopps Md -*

17. Burial *Burial* Date thereof *5/28/48* (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory *Woodlawn* (h)

Location *Baltimore Md*

18. Funeral director *William Cash Inc.*

Address *1117 St. Paul St.*

19. *May 26 1948* 9. W. *Hodson* (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County

City or town *Jopps Md* (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 24* 1948 at 5:40 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *May 1* 1945 to *May 24* 1948 and that I last saw her *alive* on *May 24* 1948

Immediate cause of death *Carcinoma of sigmoid with metastasis*

DURATION *2 yrs*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations *same* Date of op. *Sept 6 1947*

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Fred O. Hodson M.D.* M. D. or other

Address *Edgewood Md* Date signed *5-24-48*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. .

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05070

61
Reg. Dist. No.

185-

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Harford

City or town..... Havre De Grace

(If outside city or town limits, write RURAL and give nearest town)

one hour

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

one Hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Cecil

City or town..... Perryville

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Grace Turner Nickle

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) April 30, 1880

8. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day

68 17 hrs. min.

9. Birthplace..... Colora, Cecil Co., Md. Rural

(Town, county, and state)

10. Usual occupation..... Seamstress

11. Industry or business.....

12. Name..... Frank H. Nickle

13. Birthplace..... Cecil Co., Md

14. Maiden name..... Elizabeth H. Niblock

15. Birthplace..... Cecil Co., Md.

16. Informant..... Mrs William L. Taylor

Address..... Perryville, Md.

17. Burial..... Date thereof..... May 20, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... West Nottingham

Location..... Colora, Md. Rural

18. Funeral director..... W. A. Patterson & Son

Address..... Perryville, Md.

19. Date rec'd by registrar..... May 20, 1948

(Date rec'd by registrar)

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... 17 May 1948, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

17 May 1948, to 1948, and that I last saw her alive on 17 May 1948.

Immediate cause of death.....

Acute Pulmonary Edema

DURATION

Due to..... Cardiac Failure

(Heart)

Due to..... Hypertension A.S.C.V.D.

Other conditions..... Mild Diabetes

Mellitus

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Perryville, Md. Date signed..... May 20, 1948



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05071

CERTIFICATE OF DEATH

94a

185-

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

x yrs

Hospital, institution, or street address where death occurred:

M. Stokes St. Extended

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

Jan. 36, 1896

8. AGE:

Years

Months

Days

If less than one day

52

3

17

-

hrs.

-

min.

9. Birthplace

Harford Co. Md.

(Town, county, and state)

10. Usual occupation

Fireman

Aberdeen Evening Standard

11. Industry or business

12. Name

J. T. Simpson

13. Birthplace

N. Va. Md.

14. Maiden name

Louise Mitchell

15. Birthplace

Mrs. Ada DeBaugh

16. Informant

N. Va. Md.

17. Burial

Date thereof

May 16, 1948

(Burial, cremation, or removal) Which?

Cemetery or crematory

Rock Run Cem.

Location

Harford Co. Md.

18. Funeral director

P. J. Madison Mitchell

Address

N. Va. Md.

19. Date rec'd by registrar

May 16, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Harford

City or town

N. Va. de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No.

No. Stokes St. Extended

(If rural, give LOCATION)

2.(a) If veteran, name war

World War II

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 13

1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h. alive on

Immediate cause of death

PROBABLE CORONARY
OCCLUSION

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

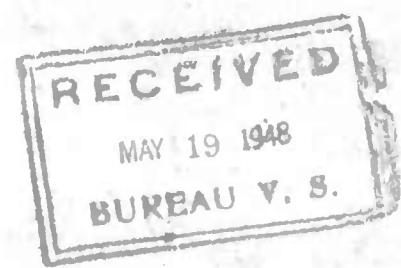
23. SIGNATURE

J. T. Simpson, M.D.
Sup. medical Examiner
Aberdeen, Md.

Address

Date signed

5/13/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05072

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

M

B

A

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
 County Harford
 City or town Thande Grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:
St. Francis Villa

How long in hospital or institution? 4 yrs.

3. (a) FULL NAME
Sister M. J. Henrietta (Marie Schraff)

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife: _____

7. Birth date of deceased (mo., day, yr.) Sept. 15- 1889 6. (c) If alive, give age _____ years

8. AGE: Years 58 Months 8 Days 15- If less than one day _____ hrs. _____ min.

9. Birthplace Germany (Town, County, and state)

10. Usual occupation Nurse

11. Industry or business

12. Name George Schraff (deceased)

13. Birthplace Germany

14. Maiden name Anna Henner

15. Birthplace Germany

16. Informant Hospital Friends

Address Thande Grace

17. Burial Date thereof 6/3/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Redeemer

Location Baltimore, Md.

18. Funeral director Pennington & Row

Address Thande Grace

19. Date rec'd by registrar June 1, 1948 A. L. Lewis M.D.
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Harford
 City or town Thande Grace (If outside city or town limits, write RURAL and give nearest town)
 Street No. Commerce & Market (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number _____

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1948 at 12:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 30 1948 to May 31 1948
 end that I last saw her alive on May 31 1948

Immediate cause of death

Arturo Pneumonia
Angina Pectoris
 Due to Calculus Thrombosis

DURATION

Due to

Cardiac Failure

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Charles J. Foley M.D.

M. D. or other

Address John and Mary Reed Date signed 6/3/48

RECEIVED

JUN 7 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05073

CERTIFICATE OF DEATH

172
Reg. Dist. No. 182

1. PLACE OF DEATH:

County

City or town

Harford Co.

State or town outside city or town limits, write RURAL and give nearest town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

ROBERT WAUGER ^{HTEL} SEIDEL

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Dorothy J. Seidel

6. (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.)

April 4 1924

8. AGE:

Years

Months

Days

If less than one day

22 1 12

hrs. min.

9. Birthplace

Lancaster Co. Pa.

(Town, county, and state)

10. Usual occupation

Mechanic Auto

11. Industry or business

Auto Garage

12. Name

Dorothy Seidel

13. Birthplace

Blacks Co. Pa.

14. Maiden name

Edith Wauger ^{HTEL}

15. Birthplace

Pa.

16. Informant

Herman Shank

Address

28 West Steigle St. Mankin

17. Burial

(Burial, Cremation, or other)

Date thereof

(month) (day) (year)

May 24 1948

Cemetery or crematory

Fairview

Location

Mankin Pa.

18. Funeral director

H. S. Bailey

Address

Arlington

19. (Date registered by registrar)

May 23 1948

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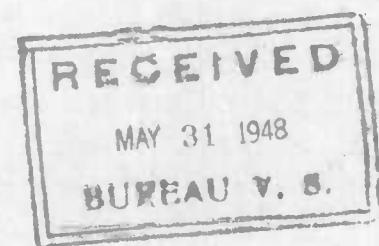
May 23 1948

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May 23 1



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05074

CERTIFICATE OF DEATH

5181
Reg. Date. No. 182

1. PLACE OF DEATH:

County

City or town

Harford

Bel Air (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

58 E Broadway

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife

Grace Davis Shannon

6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.)

Apr. 16, 1875

8. AGE:

Years

Months

Days

If less than one day

73 1 4

hrs. — min.

9. Birthplace

Harford Co. Md. (Town, county, and state)

10. Usual occupation

Gas Station Attendant

11. Industry or business

Geo. J. Shannon

MOTHER FATHER

12. Name

Md.

13. Birthplace

Md.

14. Maiden name

Annie Magle

15. Birthplace

Md.

16. Informant

Mrs. Grace Shannon

Address

58 E Broadway, Bel Air, Md.

17. Burial

(Burial, cremation, or removal)

Date thereof May 27, 1948

(month) (day) (year)

Cemetery or crematory

Rock Spring

Location

Harford Co. Md.

18. Funeral director

P. J. Madison Mitchell

Address

Lavende Grace, Md.

19. Date rec'd by registrar

57-21

19.48

Reflowood

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State

Md.

County

Harford

City or town

Bel Air

(If outside city or town limits, write RURAL and give nearest town)

Street No.

58 E.

Broadway

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 20 1948, at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1939, to May 20 1948

and that I last saw him alive on May 20 1948

Immediate cause of death

Carcinoma prostatic in prostate - Seminal vesicles - Liver -

Due to

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

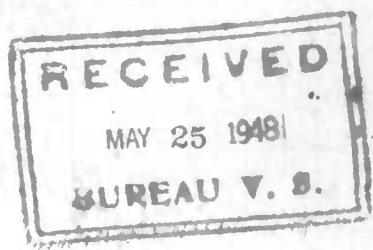
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Bel Air Md. Date signed 5/20/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05075

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

M

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:
 County Harford
 City or town Havre de grace
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Harford Memorial

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil
 City or town Liberty Grove
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

3. (a) FULL NAME
WILLARD A. SMITH
 4. Sex M 5. Color of race W 6.(a) Single, married, widowed, or divorced
Single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo. day, yr.) April 8. 1867 6.(c) If alive, give age _____ years8. AGE: Years 81 Months Days 26 If less than one day
 hrs. min. 9. Birthplace Berkeley (Town, county, and state)10. Usual occupation Seafarer

11. Industry or business

12. Name John Smith13. Birthplace Berkeley, Md.14. Maiden name Sarah McNamee15. Birthplace Md.16. Informant mrs. Clara Siddle
 Address Colona, Md.17. Burial Darlington Date thereof May 7. 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Darlington
 Location Darlington, Md.18. Funeral director J. V. Jason
 Address Rising Sun, Md.19. May 6. 1948 Date rec'd by registrar A. L. Lewis
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 May 19 48 at 30 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
15 April 19 48 to 4 May 19 48
 and that I last saw him alive on 4 May 19 48Immediate cause of death Cerebral embolism DURATIONDue to Fibrillation of heart
& mural thrombiDue to Other conditions Mr. myocarditis
Vascular occlusion bothlower legs. (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

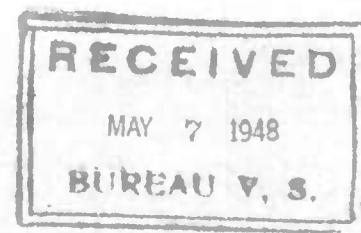
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Jason M.D. M.D. or otherAddress Harford Memorial Hosp. Date signed 4 May 48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05076

132

CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1. PLACE OF DEATH:

County HarpersCity or town Holme de Grace
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 yrs.

Hospital, institution, or street address where death occurred:

Harpers Memorial Hosp.How long in hospital or institution? 6 days.

3. (a) FULL NAME

Julia Stokha

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

W.

6. (b) Name of husband or wife

John Stokha (deceased)

7. Birth date of deceased (mo., day, yr.)

Sept. 1, 1896

6. (c) If alive, give age years

8. AGE: Years

52

Months

8

Days

5

If less than one day

hrs.min.

9. Birthplace

Czechoslovakia

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

MOTHER FATHER

Agnes HallCzechoslovakiaAnna KacanaCzechoslovakiaJohn Stokha (deceased)

16. Informant

John Stokha (deceased)102 Deaver St. Holme de Grace

17. (Burial, cremation, or removal. What?)

Cemetery or crematory

H. Johns

Location

Thruop, Pa.

18. Funeral director

Stein Funeral Home

Address

Albion, Pa.

19. (Date rec'd by registrar)

May 6, 1948A. L. Lewis, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County HarpersCity or town Holme de Grace
(If outside city or town limits, write RURAL and give nearest town)Street No. 102 Deaver
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

6 May 19481948 at 5:25

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

28 April1948 to6 May 1948and that I last saw her alive on 6 May 1948

Immediate cause of death

Shock, HemorrhageurmiaBilateral Pneumonia

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harper Memorial Hosp. M. D. or otherDate signed 6 May 48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05077

CERTIFICATE OF DEATH

93d

181

Reg. Dia. No.

1. PLACE OF DEATH:

County

City or town

Harford

Bural Glendale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Unknown

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Alexander Tscholakoff

4. Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

Male

White

Unknown

6. (b) Name of husband or wife

T. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

(Unknown) 1883

8. AGE:

Years Months Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

John S. Tamm

Address 106 George St. Glendale rd

17. Burial, cremation, or removal? Date thereof May 22 1948

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

May 22 1948 Nellie H. Riley

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Harford

City or town

Glendale Bldg

Street No.

Elmwood Board

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 20 1948 at 69 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 13 to

May 19 1948

and that I last saw him alive on

May 19 1948

Immediate cause of death

Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

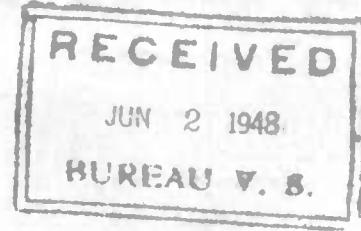
23. SIGNATURE

J. Ralph Riley M.D. or other

Address

Glendale May 22

3881
65
38461



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05678

CERTIFICATE OF DEATH

93d
Reg. Distr. No. 181

1. PLACE OF DEATH:

County

Harford

City or town

Rural Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

14 mo

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

LANEY MARION WARD

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Eleanor F. Ward

7. Birth date of deceased (mo., day, yr.)

61

years

July 12, 1879

8. AGE:

Years

Months

Days

If less than one day

68

10

10

hrs.

min.

9. Birthplace

Harford Co. Md.

(Town, county, and state)

10. Usual occupation

Gardener

11. Industry or business

Thomas J. Ward

12. Name

Md.

13. Birthplace

Sotnia Beaufort

Md.

14. Maiden name

Mrs. Eleanor F. Ward

15. Birthplace

Harde de Grace, Md. P.O. #2

16. Informant

Burial

Date thereof May 26, 1948

Date thereof

month

day

year

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Deer Creek Methodist Ch. y.d.

Cemetery or crematory

Harford Co. Md.

Location

T. Madison Hatchell

Funeral director

Harde de Grace, Md.

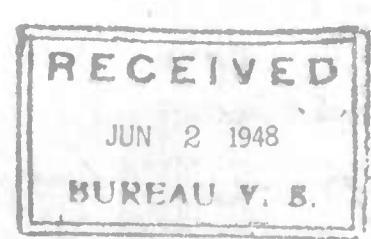
Address

17. Burial

Nellie H. Riley

(Date record by registrar)

Date record by registrar



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05079

182

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Hartford

City or town.....

AlDina

Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Joan Isabel

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

9

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

April 20 - 1948

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

It less than one day

18

hrs.

min.

9. Birthplace.....

AlDina

(Town, county, and state)

10. Usual occupation.....

V

11. Industry or business

MOTHER FATHER

12. Name.....

Alvin L. West

13. Birthplace

N. C.

14. Maiden name.....

Dorothy Honakar

15. Birthplace

Md

16. Informant.....

Alvin L. West

Address

Aberdeen Rd 2

17. Burial

Burial

Date thereof.....

May 9/48

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Mt. Zion

Location.....

Fountain Green

18. Funeral director.....

Joseph J. Teller

Address

Bel Air Md

19. (Date record by registrar)

5/8/48

19.

P. Foword

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Hartford

City or town.....

AlDina

Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

West

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 8 1948 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased item

April 20 1948 to May 8 1948 and that I last saw her alive on April 27 1948

Immediate cause of death.....

Erythroblastosis foetalis

DURATION

Life

Due to.....

Due to.....

Other conditions.....

Prematurity
(at 8 mo)

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Gerald C. Palmer M.D.

M. D. or other

Address.....

Bel Air Md

Date signed 5/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

RECEIVED
MAY 11 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05080

CERTIFICATE OF DEATH

93d Reg. Dist. No. 182

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 2 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Anna May Wiggers

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married

6. (b) Name of husband or wife

Charles E Wiggers

6. (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.)

Feb 9, 1879

8. AGE:

Years

Months

Days

If less than one day

74 2 24

. hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Samuel B James

MOTHER FATHER

12. Name

Samuel B James

13. Birthplace

Root Grove

14. Maiden name

Anna Reese

15. Birthplace

Harford Co Md.

16. Informant

Mrs. Fletcher B Creaswell

Address

Bel Air Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 5, 1948

(month) (day) (year)

Cemetery or crematory

Freudship, ~~Freudship~~

Location

Fallston Md.

18. Funeral director

Martha Frey

Address

Jagettsville

19.

5/4/48

P. F. Hudson

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Harford

City or town

Bel Air

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 2, 1948 at 7:30 M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19, 1948 to May 2, 1948

and that I last saw her alive on April 30, 1948

Immediate cause of death

Coronary Thrombosis
Terminating

Due to

Chr Cardiosclerosis
disease with decompensation

Due to

2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Willard P. Hudson M.D.

M.D. or other

Address

Forest Hill Md.

Date signed 5/3/48

